HEALTH CARE FOR UNDOCUMENTED IMMIGRANTS:

A Discussion Paper

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The purpose of this paper is to stimulate debate and discussion on the issue of health care services for undocumented immigrants. In this environment of health care reform, public health officials and other health advocates have expressed concern that the health care needs of undocumented immigrants have not been addressed. The authors express the concern that neglect of primary care and public health needs of undocumented immigrants will result in higher health care costs to society because treatment delays result in more serious illnesses and spread of communicable diseases.

Dr. Jack Dillenberg is the Director of the Arizona Department of Public Health. After describing the extent and scope of issues raised in denying primary and preventive health care services to undocumented immigrants, he and co-author Merrill Krenitz, Planning and Evaluation Coordinator, propose a number of policy and research initiatives to address some of the health concerns.

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PUBLIC HEALTH
AND
UNDOCUMENTED IMMIGRANTS

A Discussion Paper

Health care for undocumented immigrants is not a popular issue. Recent polls indicate that most Americans are willing to pay additional taxes to support health care for other Americans, but not for people who have come into the country without permission. In fact, for some people, health services for undocumented immigrants is a non-issue. Their contention is that if a person is not a legal resident of the U.S., he or she should just go home - where ever that is - to get care; "*those people*" are just not our problem.

However, for many policy makers and members of the general public, especially in areas with large immigrant populations, this is an extremely serious issue which requires much more attention. If we are to have true reform of our health care system, the cost of providing services to, and the control of contagious diseases among, this population are problems which must be addressed.

The unwillingness of the general population and many legislators to consider the health service needs of undocumented immigrants is primarily the result of the widespread belief in the following two myths about this population.

MYTH NUMBER 1: Immigrants have an adverse effect on the economy.

There is a pervasive notion in the general population that immigrants take jobs away from native-born Americans and/or they are a drain on the economy. There are many studies from a variety of government and private agencies (of all political persuasions) which refute this idea, and show that immigrants generate more jobs than they take.

MYTH NUMBER 2: Immigrants come here to take advantage of our health and welfare systems.

As previously stated, many people believe that immigrants are heavy users of health and social services and as such are a burden to taxpayers. This belief has also proved to be unfounded. Immigrants generally represent a federal tax windfall as they contribute significantly more in taxes than they consume in benefits. Undocumented immigrants are likely to be proportionately even higher contributors, as they cannot participate in most state and federal health and social service programs. A recent study by the Urban Institute indicated that taxes on earnings of immigrants result in a surplus of revenues over social services costs. One problem is that revenues are unevenly distributed, so that the federal government shows a surplus while state and county governments show a deficit.

The point in examining these myths is to call attention to the fact that decisions about services for the undocumented population are being made on the basis of mistaken "conventional wisdom" and not on empirical evidence. Further, these widely held beliefs have blocked any but the most limited discussions of the costs versus the benefits of providing services. The time has come, however, to discard the myths and look, in a practical and realistic way, at the issues that surround the provision of health care to undocumented immigrants.

First, we need to start by admitting that borders are just imaginary lines that are drawn on maps for political purposes. Since the dawn of humans, people have pushed the edges of their universes. They were not stopped by oceans, deserts, mountain ranges or, most recently, gravity. The wall did not work in Berlin, and it does not work in Yuma, Douglas, Nogales, San Diego, El Paso or any other border town or major metropolitan area that people can access by boat or plane. The movement of people cannot be totally controlled.

Next, we must accept that people bring their health status with them. The majority of people who immigrate to the U.S. are generally healthy when they get here. The primary reason for this is that immigrants tend to be younger people who come here looking for work and are prepared to live under difficult circumstances until they can become established. But if immigrants do have health problems in their native countries they do not drop those problems off at that imaginary line, the border, and enter the U.S. healed.

Finally, we must agree that there is a hierarchy in the cost of health services with emergency services being the most costly form of care which can be provided. There are many reasons for this including:

1. care provided in emergency rooms is billed at a higher rate than the same service provided in a clinic or physician's office;

2. health problems are generally at a more advanced stage when a person finally arrives at an emergency room thus requiring more intensive interventions (e.g., treating hypertension versus treating stroke);

3. health issues left unattended can have long range, costly consequences (e.g., rehabilitation and special education for an infant born very prematurely); and

4. people with contagious diseases can infect many others before feeling sick enough to present at an emergency room for treatment.

In summary, if we accept the premises that: people will cross borders regardless of efforts to prevent this; people bring their health problems with them from their country of origin; and emergency health care is the most costly we can provide; it becomes understandable why it is important for all people, regardless of the circumstances under which they entered

the country, to have access to basic health care.

The issue then becomes: how can states afford to do this? The response is that health services for undocumented immigrants is not just a border state issue, not just a U.S. issue, but a multi-national issue. The border states - Arizona, California, New Mexico, and Texas - along with Florida, Illinois, Michigan and New York do have the most pressing problems with providing services for this population, but virtually every other state in the country is involved. Further, the federal government sets immigration policy yet state governments are responsible for all services that immigrants require. Finally, people are mobile - particularly in the border areas - and, therefore, so are health issues.

The solution to the problem of providing health care to undocumented immigrants must come from actions taken at the national level. These actions will require legislation, policy changes, and international agreements. The following are suggestions for developing a rational approach to this issue.

1. **Develop and implement a coherent, practical immigration policy that recognizes that people will, and are, traveling across borders.**

   Our current methods for dealing with entry into the U.S. are not working. First, it is estimated that for every illegal immigrant captured, five to ten others slip through. Next, the time delays at border crossings are creating havoc. The increased traffic resulting from the North American Free Trade Agreement (NAFTA) will only exacerbate problems.

   Another serious issue is the economic burden to local governments for providing health, education, and social services to children born in the U.S., and thus being American citizens, who live in Mexico. These children are entitled to a wide array of benefits, yet their families contribute nothing to the tax base of the local communities providing those benefits as they neither live nor work in them.

   Finally, as our system virtually takes a head in the sand approach, our knowledge about undocumented immigrants is extremely limited. No one actually knows how large this population is (the number has been estimated at between 1.7 and 6 million nationwide) let alone what the health care needs are.

   Just adding more Border Patrol agents will not solve the problem; it is impossible to control every potential entry point into the country. The visa system is not working either; hundreds, if not thousands, of "tourists" stay and take up residence each year. We need a system which acknowledges people's entry and departure in a rational, manageable method.

2. **Develop and implement a uniform set of rules regarding eligibility for services that is consistent for all federal programs.**

Regardless of residence status, the variance in eligibility criteria for federal programs serving similar target populations is staggering. For example, the WIC and Food Stamp programs are governed by the U.S. Department of Agriculture yet both programs define income and household differently. This makes it extremely difficult for states trying to merge services for more efficient delivery to communities to develop common eligibility forms, write procedures, and train staff. The problems increase geometrically as other programs (e.g., housing, Medicaid) are added to the mix.

The problem is further exacerbated when verification of residence status is required. People who have been authorized to live in the U.S. under Section 245A of the Immigration law are not able to participate in federal programs based on financial need such as AFDC, Food Stamp, and certain forms of Medicaid. However people who qualify for residence under Section 201A are eligible for most programs once they formally acquire temporary status.

Eligibility for federal programs is based not only on a wide array of federal laws, but an even greater number of regulations and judicial interpretations. This not only makes it very difficult for states to administer programs, but it often results in eligible people being denied services because local workers are lost in confusing, occasionally conflicting, procedures. This confusion has the net effect of wasting resources. The resources needed to administer such complexity, as well as fight all the resultant legal battles, are staggering.

3. **Adopt formal agreements with other countries for sharing case management of individuals with contagious diseases which include: development of an infrastructure for coordinating case management; and standardization of procedures, medications and sterilization practices.**

AIDS, hepatitis B, and tuberculosis as well as a host of other contagious diseases have no respect for borders. People, whether only carriers or actively infected, transmit these diseases to others they come in contact with. If the public health communities are to achieve any measure of control it must come through the coordination of efforts within regions, regardless of any geopolitical boundaries.

Coordination activities include: timely sharing of medical record data (e.g., patient history, diagnosis, treatments); continuity of care; tracking systems; and protocols to standardize procedures, medications, and infection control practices. This will require that there be an infrastructure in the U.S. and other countries which is capable of accepting these responsibilities.

4. **Develop and implement systems for monitoring and conducting surveillance of**

individuals with communicable diseases; environmental hazards; food and product safety inspections; and occupational safety.

Public health professionals have long recognized monitoring and surveillance as basic tools for protecting the health of communities. As described above, it is essential to track the care provided to individuals with contagious diseases in order to ensure completion of treatment regimes as well as provide continuing education on appropriate health related behaviors. Monitoring environmental situations is essential for protecting people, as well as providing data for use in analysis of disease outbreaks (e.g., the lupus epidemic in Nogales). An improved system of inspection of goods for compliance with U.S. standards for food and product safety is already needed; the current system is strained beyond capacity. Monitoring occupational safety has been shown to be a significant issue based on problems seen in the maquiladoras now operating.

As discussed in the suggestion on immigration policy, in order to prevent and control problems it is essential to have accurate baseline data. Just as we need a better system to monitor and describe the immigrant population, we need adequate information systems for health issues. These systems need to be developed through cooperative partnerships with representation from national (U.S. and Mexico), state and local governments, public health experts, and industry.

5. **Create a system that provides a basic set of health services that is available for all people.**

As discussed above, most people do not come to the U.S. for the sole purpose of taking advantage of our welfare systems. Unfortunately, even those who arrive with the best of intentions occasionally need medical care. Whether it is because of illness, injury, or pregnancy, undocumented immigrants require health services in the same way as all other residents. Forcing the undocumented to wait until their conditions are serious enough to warrant attention in an emergency room is in no one's best interests.

There are, however, some people who do come to the U.S. only for medical care. They do so because there are no adequate services in their home communities. For example, the Holy Cross Hospital and Health Center in Nogales, Arizona provides care to Mexican nationals who may drive as many as 200 miles for services. These people are not seeking to live in the U.S., they just want health care. When a pregnancy is involved, this situation then contributes to the immigration policy issue of granting citizenship to anyone born in the United States. This then feeds into the problems that U.S. border cities are having with funding services for citizens who do not contribute to the tax base.

The solution to providing health care for undocumented immigrants must be two pronged. The health services infrastructure in Mexico needs to be enhanced in order to meet local needs. Health services policy in the U.S. needs to be revised to incorporate the philosophy of disease prevention and early intervention for all people. The changes for both systems will require significant investment of resources in the early stages.

6. **Adopt formal agreements with other countries to obtain payment for health services provided to their citizens.**

   The U.S. does not have the resources to provide total health care to everyone in the world who requires it. There needs to be a mechanism for compensating the U.S. for health services given to citizens of other nations. Unfortunately, many of the people immigrating to the U.S. are coming from countries with serious economic problems.

   The situation is also complicated by the fact that there are some economically self-sufficient people who come to the U.S. and pose as indigents in order to take advantage of the system. While the number of people who do this is relatively small, there are enough to require that this issue be addressed.

Health care is an international issue for both developed and developing countries. As Winston Churchill said: "Healthy citizens are the greatest asset any country can have." The cost of providing health care needs to be included in international development packages and trade agreements, as well as in immigration and travel agreements.

The U.S. is in a period of economic and societal transition. The provision of health services is only one facet of the change that is taking place. At this time there is tremendous potential to correct many failed policies; policies that ignore the realities of the way people live or which are "penny wise and pound foolish." The ideas presented in this discussion paper are intended to call attention to the need to address health care as part of the larger system of interaction between peoples and nations. The goal of this paper is to provide an holistic view of the problems and opportunities for resolving difficult issues.

POTENTIAL PROJECTS

The following projects all have the same underlying premise: At the same time that regional economic zones are being developed, regional health zones also should be developed. For much of history, economic development came first with health becoming an issue as people became more affluent. In addition to the waste created through environmental pollution and the massive amounts of resources needed for clean up, there was also an enormous cost in lost human potential as well as in sickness care. It is our contention that development of human resources should occur concurrently with that of industrial resources. The projects described below provide relatively low cost methods to promote and maintain health.

1. Hand-held Medical Record

Continuity of care is a major issue for transient populations; and is particularly important for young children. It is essential that health care providers be able to monitor growth and development and immunizations received, as well as to track any special health problems.

The Arizona Department of Health Services is developing a hand-held medical record system. The record will be composed of multi-part medical documentation forms, health promotion information sheets and next visit reminder sheets.

It is proposed that this system be made culturally and linguistically appropriate for use with Mexican families and providers. Individual record books would be distributed to all infants born in hospitals in Arizona and Sonora, Mexico. The Department would train providers in its use so that systematic care can be provided to children. Funding is needed to develop, print and distribute the Spanish version of the records, train health care providers in its use, and evaluate the impact on the health of children.

2. Insurance Reciprocity

At this time, individuals traveling in foreign countries are generally responsible for their own medical care even if they have some benefit plan at home. Thus if a medical emergency occurs to a person while out of country, the person is either out of pocket for the costs of care or the local medical system absorbs the cost.

It is proposed that an agreement between the Mexican Medical System and the Arizona Medicaid program be piloted. Under this agreement Arizona would agree to reimburse Mexico for care provided to its plan members and *vice versa*. Support would be needed: for identification of legal and financial issues; legal work to develop the agreements, to inform citizens and providers of processes to be used; and to evaluate the impact on both states' health care systems.

This arrangement ultimately could be part of a broader health component of the NAFTA. As trade increases and businesses become more multi-national, it will be important for employees to be able move freely between countries with the knowledge that their health benefits are consistent and secure. It will also have implications for travel and tourism. For example, Canadian winter residents of Arizona have had their health benefits reduced because of the cost of health care here. This may end up having a negative impact on the Arizona economy if Canadians stop coming and /or reduce the time they stay because of health concerns.

3. Case Management of Communicable Diseases

Treatment of tuberculosis and HIV are growing public health problems. In border areas, where there is routine and frequent migration, maintaining treatment regimes is a serious problem. Aside from standardization of treatment protocols, there is the issue of gaps in care as people transition between providers.

It is proposed that a program to facilitate coordination of care be established. Ideally, this should be done in conjunction with the agreement for insurance reciprocity in order to assure that an undue financial burden is not placed on either health system. Funding would be required to develop the treatment protocols, train providers in their use, implement systems of case management, and evaluate effectiveness.

4. Case Management of Children with Special Health Care Needs

By their very nature, children with special health care needs require additional services in order to achieve their full potential. Many of the children living in border areas with special needs, regardless of their citizenship, end up in Arizona treatment facilities. It is our contention that children do best, however, when care is culturally competent, community based, and family centered.

It is proposed that a program to provide case management to children with special needs living in border areas be established. This program would integrate the knowledge and skills of providers in Arizona and Sonora to develop coherent, consistent systems of services for children. Again, this should be done in conjunction with the above pilot for insurance reciprocity. Funds would be needed to develop treatment protocols, train providers in their use, implement systems of case management, and evaluate effectiveness.

5. Emergency Medical Services

Arizonans having emergency medical needs while in Mexico often encounter major

problems in returning home for treatment. Also, certain tertiary care treatment centers in Arizona might be the closest appropriate facility for Sonorans needing emergency care, yet they too have major difficulties accessing these centers. Part of the problem is that border crossings close at night. Another issue is the ability of emergency care providers and transport vehicles to enter Arizona from Mexico, and *vice versa* because of lack of reciprocity of medical licensure. And finally, there is the issue of who pays for what parts of the emergency services.

It is proposed that formal agreements be developed to cover emergency medical care in the Arizona - Sonora region. One component would be to declare Puerto Penasco a free port. Other components would be: treatment protocols; standards of care; provider skills; emergency border crossing procedures; and payment mechanisms. Again, insurance reciprocity, in addition to medical/nursing license reciprocity, would need to be arranged. Funds would be needed to develop treatment protocols, train providers, and evaluate effectiveness.

6. Hospital Data Systems

At the present time, hospitals in border areas perceive that they are losing large amounts of money in the provision of services to undocumented immigrants. However, a review of the literature fails to provide a clear understanding of what data are being used to reach that conclusion. If border hospitals are presuming that all Hispanics with no health insurance are undocumented, we could be seriously underestimating the number of legal residents who will need attention through health care reform. If their data is valid, then a system for insurance reciprocity becomes even more important.

Projects are needed to conduct an evaluation of hospital data to develop a baseline for determining the level and value of care provided to undocumented immigrants.

This discussion has outlined a case for health care services to be provided to undocumented workers in spite of a current political environment which is opposed to spending public dollars on non-citizens. State and international boundaries are ineffective barriers to control the spread of disease; for this reason alone, a regional strategy for providing preventive and public health services must be adopted. A number of policy changes, along with some alterations in health care systems, and implementation of targeted research and evaluation projects could address both health and economic concerns along national border areas.

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ADDITIONAL RESOURCES

The Urban Institute is a nonprofit, nonpartisan policy research institute in Washington, D.C. The Institute seeks to sharpen thinking about society's problems and efforts to solve them, improve government decisions and performance, and increase citizen awareness of important public choices. Information about Urban Institute programs and publications is provided for those interested in exploring the issues related to immigrants and undocumented immigrants.

SELECTED URBAN INSTITUTE PUBLICATIONS ON IMMIGRATION AND IMMIGRANT POLICY

Immigrant Policy Program
The Urban Institute's Immigrant Policy Program was created in 1992 with support from the Andrew W. Mellon Foundation. The overall goal of the program is to research, design, and promote policies that integrate newcomers into the United States. To that end, the program seeks to: 1) Develop systematic knowledge on immigrants' economic mobility and social integration, and the public policies that influence them; 2) Disseminate knowledge broadly to government agencies, non-profit organizations, scholars, and the media; and 3) Advise policymakers on the merits of current and proposed policies.

Program for Research on Immigration Policy
The Program for Research on Immigration Policy was established in 1988 with initial core support from The Ford Foundation. The program is dedicated to supporting the formulation of immigration and immigrant policies at the state and national levels and in relevant areas of the private sector. It has three basic goals: 1) To study the important domestic and international issues raised by the Immigration Reform and Control Act (IRCA) of 1986 and the Immigration Act of 1990; 2) To address the larger, continuing questions and problems of immigration and immigrant policy; and 3) To disseminate and exchange information about immigration and immigrant policy through publications and conferences.

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